Plan and provider collaboration to improve the quality of health care and services provided to Aetna Better Health members.

Partnerships that will lead to improved scores and healthier member outcomes!

Provider and health plan partnerships will close care gaps, enrich care delivery, improve data capture, and engage membership. This results in improved quality scores and healthier member outcomes. Please review this sheet on the P4Q program, how you are eligible to participate, and what the potential incentive payment is you could receive.

Program Timeline

- The program measurement year is the 2019 calendar year for dates of service January 1 - December 31, 2019
- Maternity measures include care of members with deliveries from November 6, 2018 – November 5, 2019

Provider Eligibility

- Panel requirements vary by measure; please refer to Pay for Performance Measures section of this document for a listing of measures in the program and panel requirements

Incentive Payments

- Care must be captured administratively through claims
  - Medical record submission will not count towards P4Q payments
  - Recommended code classes are CPT or ICD-10
  - There is a large list of approved NCQA codes used to identify the services or conditions included in the measures in the P4Q program. Just a few of the approved codes are included in this document. For a full list please go to the National Committee for Quality Assurance's website, www.NCQA.org.
- Please review coding tips provided in this handout or contact Aetna Better Health’s Quality Management Department for additional approved NCQA Coding Tips at AetnaBetterHealthPAQM@aetna.com
  - Providers may resubmit claims for care in applicable measurement periods not captured administratively. Claims must be resubmitted as a correct claim type
- Incentive payments are attributed to eligible practice TINs in one of two ways:
  - Achieving the required NCQA benchmarks or thresholds for a specific HEDIS® (Healthcare Effectiveness Data and Information Set) measure OR
  - Based on each member that receives the required service for measures where there is no minimum benchmark or threshold.
- Please refer to Pay for Performance Measures section of this document for a listing of measures in the program and specific incentive payment information
2019 Pay for Performance Measures

Measures with Annual Incentive Payment

Incentive payment to occur June 2020 following completion of calendar year 2019.

Comprehensive Diabetes Care: HbA1C Poor Control \( \geq 9\% \) (CDC \( >9\% \)) - Primary Care Providers

- Minimum panel requirement - 50 members
- Population: Members age 18-75 years with type 1 or type 2 diabetes whose most recent HbA1C in 2019 is \(<9\%\) as shown through claims data or by services that Quest Labs and LabCorp obtain (Aetna Better Health's lab vendors)
- The Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control \( \geq 9\% \) measure is an inverse HEDIS measure, therefore you would want your reports to reflect members not adherent for this measure
- Incentive: **$20.00** once per member whose last HbA1c in calendar year 2019 is \(<9\%\)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Code Description</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDC &gt;9%</td>
<td>HbA1c Test</td>
<td>83036, 83037</td>
</tr>
<tr>
<td>CDC &gt;9%</td>
<td>HbA1c Levels</td>
<td>3044F, 3045F, 3046F</td>
</tr>
</tbody>
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Controlling High Blood Pressure (CBP) - Primary Care Providers

- Minimum panel requirement - 50 members
- Population: Members from age 18 and older who have a diagnosis of hypertension
- Members age 18-85 must have a last recorded (representative) BP of \(<140/90\) in 2019
- Associated diagnosis of hypertension must also be captured twice in 2018 or 2019
- Representative BP - taken on or after the second diagnosis of hypertension is captured
  - Representative BP must be the last BP taken in the measurement year
- If multiple BP’s are taken on the same visit- we will use the lowest systolic and lowest diastolic reading
- No BP measured in 2019 - member is considered not controlled
- Data Capture- CPT II codes indicating controlled representative BP reading. Associated diagnosis of hypertension must also be captured. (2 visits)
- Incentive: **$25.00** once per member whose last recorded BP reading of 2019 is:
  - \(<140/90\) for members ages 18-85 years
  - Highest compliant BP 139/89

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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>CBP</td>
<td>Essential (primary) Hypertension</td>
<td>I10</td>
</tr>
<tr>
<td>CBP</td>
<td>Systolic Reading</td>
<td>3074F, 3075F, 3077F</td>
</tr>
<tr>
<td>CBP</td>
<td>Diastolic Reading</td>
<td>3078F, 3079F, 3080F</td>
</tr>
</tbody>
</table>

Medication Management for People with Asthma 75% (MMA) - Primary Care Providers

- Minimum panel requirement - 50 members
- Population: Members ages 5 – 64 years of age who were identified as having persistent asthma
- These members were dispensed appropriate medications that they remained on during 75% of the treatment period as shown through pharmacy claims
- Incentive: **$20.00** once per member diagnosed with persistent asthma who remains on appropriate medications during 75% of the treatment period
Ambulatory Care - Emergency Department Visits

✓ Minimum panel requirement - 200 members
✓ Population: All members who utilize the Emergency Room for ambulatory care services that did not result in an inpatient admission
✓ Thresholds for payment: 60.39 visits/1000 member months to realize payment; higher payment will be awarded to providers who achieve a threshold of 50.63 visits/1000 member months
  - Measure is inverse – lower number of ED visits is desirable
✓ Incentive: **$1000** per TIN for reaching 60.39 visits/1000 member months; **$2000** per TIN for reaching or exceeding 50.63 visits/1000 member months

Plan All Cause Readmission

✓ Providers must have a minimum of 25 admissions
✓ Thresholds for payment: minimum 30 day readmission rate of 8.0%; additional payment will be rewarded to providers with a 30 day readmission rate of 7.0% or less
✓ Measure is inverse – lower number of readmissions are desirable
✓ Providers will receive **$1500** per TIN for a 30 day all cause readmission rate of 8.0%; **$2500** per TIN for a 30 day all cause readmission rate of 7.0% or better

Measures with Quarterly Incentive Payment in 2019

**Adolescent Well Care Visits (AWC) - Primary Care Providers**

✓ Minimum panel requirement - 50 members
✓ Population: Members age 12 - 21 who receive one well-visit between 1/1/19-12/31/19
✓ Incentive: **$25.00** once per member ages 12 - 21 years that receives at least one well visit during calendar year 2019

**Well Child in the First 15 Months of Life, 6 or More Visits (W15) - Primary Care Providers**

✓ Minimum panel requirement - 50 members
✓ Population: members who turn 15 months old during 2019 who have had 6 or more well visits with a PCP during their first 15 months of life
✓ Incentive: **$50.00** once for each member who has at least six well visits with their PCP during their first 15 months of life

**Well Child in 3, 4, 5, 6 Years of Life (W34) - Primary Care Providers**

✓ Minimum panel requirement- 50 members
✓ Population: Members 3, 4, 5 or 6 years of age who receive one well-visit between 1/1/19 - 12/31/19
✓ Incentive: **$25.00** once for each member ages 3, 4, 5 or 6 years who has at least one well visit during calendar year 2019

<table>
<thead>
<tr>
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<th>Code Description</th>
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</tr>
</thead>
<tbody>
<tr>
<td>AWC, W34, W15</td>
<td>Well Care Visit</td>
<td>99381-99385, 99391-99395, 99461</td>
</tr>
</tbody>
</table>
Dental- Fluoride Varnish Application - Primary Care Providers

- No minimum panel requirement
- Population: member ages 0 – 5 years who receive one appropriate application of fluoride varnish between 1/1/19 - 12/31/19
- Incentive: $10.00 once per member ages 0 – 5 years for each appropriate application of fluoride varnish during calendar year 2019
  - Care is captured in claims via CPT code 99188 and ICD-10 diagnosis code Z41.8 and for referral of member to a dentist evidenced by YD modifier submitted with code for fluoride application

Maternity Measures - Family Practice PCP or OB/Gyn

- 3 HEDIS Measures: Frequency of ongoing prenatal care (FPC); prenatal care in the first trimester (PPC-Timeliness); postpartum care (PPC - Post-partum Care)
- No minimum panel requirement
- Population: Members who deliver between 11/6/18 - 11/5/19
- HEDIS Measure Incentive: $100.00 per measure ONCE for each member that meets the following requirements:
  - Completes 81% of the recommended prenatal visits
  - Completes a prenatal visit during the first trimester or within 42 days of enrollment in to the plan
- HEDIS Measure Incentive: $150.00 per member who has one postpartum visit 21-56 days post delivery
- Total potential incentive payment - $350.00 per member

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<tbody>
<tr>
<td>FPC</td>
<td>Standalone Prenatal Visit</td>
<td>99500, 0500F, 0501F, 0502F</td>
</tr>
<tr>
<td>PPC - Timeliness</td>
<td>Standalone Prenatal Visit</td>
<td>99500, 0500F, 0501F, 0502F</td>
</tr>
<tr>
<td>PPC - Post-Partum Care</td>
<td>Post-Partum Visit</td>
<td>Z01.411, Z01.419, Z01.42, Z30.430, Z39.1- Z39.2</td>
</tr>
</tbody>
</table>

Incentive to occur 30 days following data submission

Electronic Submission of Data - PCPs in the Philadelphia, southeastern region of Pennsylvania

- No minimum panel requirement
- Providers must actively participate in the exchange of member specific data with HealthShare Exchange of Southeastern Pennsylvania (HSX)
- Payment for participation comes out of a shared pool of $30,000 annually upon confirmation that connection has been achieved and data exchange has occurred
- Eligible submissions: mandatory measures, optional measures, the Obstetrical Needs Assessment Form (ONAF), or any Clinical Quality Measure (CQM) approved by the current CMS meaningful use electronic health record program rules

Payment for the P4Q program is dependent on the funding that the Pennsylvania Department of Human Services provides. Aetna Better Health reserves the right to end the P4Q program if funding becomes unavailable.